California Children's Services Program Redesign

Advisory Group Meeting

January 6, 2016

Agenda

9:30-10:00	▪ Registration, Gather, and Networking
10:00-10:15	▪ Welcome, Introductions, and Purpose of Today's Meeting
10:15-10:45	▪ Follow-Up From Previous Meeting, Key Updates, and Future Meetings' Topics/Goals
10:45-12:15	▪ Medi-Cal Managed Care Health Plan and CCS Requirements
12:15-12:45	▪ Lunch (Provided to CCS AG Group Members)
12:45-1:15	▪ Medi-Cal Managed Care Health Plan Readiness
1:15-1:45	▪ Medi-Cal Managed Care Health Plan Monitoring
1:45 – 2:00	▪ Care Coordination / Medical Home / Provider Access TWG Update
2:00-2:40	▪ Data & Quality Measures TWG Update
2:40-2:55	▪ Public Comments
2:55-3:00	▪ Next Steps and Next Meetings

Welcome, Introductions, and Purpose of Today's Meeting

Bobbie Wunsch

Pacific Health Consulting Group

Follow-Up from Previous Meeting, Key Updates, and Future Meetings' Topics/Goals

Jennifer Kent
Director, DHCS
Anastasia Dodson
Associate Director for Policy, DHCS
Sarah Brooks
Deputy Director of Health Care Delivery Systems, DHCS

Medi-Cal Managed Care Health Plan and CCS Requirements

Sarah Brooks
Deputy Director of Health Care Delivery Systems, DHCS

Lunch

(Provided for AG Members)

Medi-Cal Managed Care Health Plan Readiness

Nathan Nau
Managed Care Quality and Monitoring Division Chief, DHCS

Javier Portela
Managed Care Operations Division Chief, DHCS

Plan Readiness

- DHCS conducts a comprehensive review, analysis and evaluation of each health plan's ability to implement services related to a transition or implementation of a new benefit or population.
  - For Knox Keene licensed plans, the review process is performed in collaboration with DMHC.
  - COHS plans that are not Knox Keene licensed are reviewed and approved by DHCS. DHCS utilizes the same standards and provisions as applied to Knox Keene licensed plans.

Plan Readiness

- The plan readiness review process focuses on the following areas:
  - Provider network adequacy
  - Member communications
  - Contractual and regulatory compliance

Plan Readiness – Provider Network Adequacy

DHCS reviews and approves health plan provider network data that includes:

- Provider Network – ensures health plan networks are adequate to provide timely and geographical access to care prior to implementation
- Provider Crosswalk Match – allows for continuity of care with current treating provider with least amount of disruption to member

Plan Readiness – Member Communications

DHCS reviews and approves all applicable member materials to ensure impacted members are thoroughly informed and educated regarding the transition. These items include:

- Member Notices
- Evidence of Coverage/Member Handbook
- Member Informing Materials
- Website Resources

Plan Readiness - Compliance

To ensure compliance with contractual requirements, DHCS reviews and approves:

- Deliverables/Policies & Procedures
  - For example, Provider Network, Access Standards, Credentialing Policy, Grievances and Appeals
- Assessment Protocols
  - For example, Risk Stratification/Health Assessment Protocols (SPD Transition)
- Memorandum of Understanding
  - For example, county mental health, local health department, local education agency, regional centers (BHT)
- Continuity of Care Provisions

Medi-Cal Managed Care Health Plan Monitoring

Nathan Nau
Managed Care Quality and Monitoring Division Chief, DHCS

Javier Portela
Managed Care Operations Division Chief, DHCS

Transitional Monitoring

- DHCS conducts transitional monitoring following implementation
  - Duration:
    - Monthly for the first six months (at a minimum)
    - Quarterly thereafter
      - Typically occurs for one to two years
      - DHCS determines when to stop transitional monitoring based on data analysis and plan performance

Transitional Monitoring Cont.

- Data elements are dependent on the transition but generally include:
  - Continuity of care
  - Net change of the network size
  - Grievance and appeals
  - Utilization rates
  - Assessment rates and timeframes
  - Call Center
  - Call campaign

Monitoring in General

DHCS monitors many health plan compliance areas ongoing including:

- Network Adequacy
- Audits and Surveys
- Grievances and Appeals
- Continuity of Care
- Ombudsman
- Quality
- Data and Statistics

Network Adequacy Monitoring

Timely Access Standards

- Urgent Appointments
  - For services that do not need prior approval - 48 hours
  - For services that do need prior approval - 96 hours
- Non-Urgent Appointments
  - Primary Care - 10 business days
  - Specialists - 15 business days
  - Appointment with a mental health care provider (who is not a physician) - 10 business days
  - Appointment for other services to diagnose or treat a health condition - 15 business days

Network Adequacy Monitoring Cont.

- DHCS conducts a timely access study through annual medical audits
  - Provider survey
  - Results posted to the DHCS website
  - Action taken when health plans are not in compliance
    - Corrective Action

Network Adequacy Monitoring Cont.

Time and Distance

- Primary Care Requirement: 30 minutes or 10 miles
  - GeoAccess reports
  - Quarterly provider network reports

Network Adequacy Monitoring Cont.

Provider Ratios

- PCP
  - 1:2,000
- Physician
  - 1:1,200
- Specialists
  - Health Plan must maintain adequate numbers and types of specialists within their network to accommodate the need for specialty care

Managed Care Monitoring Information

- Managed Care Dashboard
  - Published quarterly
  - Contains information on the managed care demographics, quality metrics, continuity of care, grievances and appeals, etc.
  - http://www.dhcs.ca.gov/services/Pages/MngdCarePerformDashboard.aspx

Managed Care Monitoring Information

- Monitoring Overview
  - Summary that includes 55 monitoring processes
  - Final version will be posted to the DHCS website in January 2016
  - http://www.dhcs.ca.gov/services/Pages/ManagedCareAdvisoryGroup.aspx
- Managed Care Dashboard
  - http://www.dhcs.ca.gov/services/Pages/MngdCarePerformDashboard.aspx

Care Coordination / Medical Home / Provider Access Technical Workgroup Update

Anastasia Dodson
Associate Director for Policy, DHCS

December 11 Agenda

- **An Overview of California County Public Mental Health Services for Children** – Presented by County Behavioral Health Directors Association of California
- **Integration of Behavioral Health Services for Children with Chronic Illness** – Presented by CHOC Children's Hospital
- **Alameda County CCS Mental Health Initiative** – Presented by Alameda County's Mental Health Initiative Coordinator and CCS Behavioral Health Care Services Children's System of Care

Webinar recording available on AG website:
http://www.dhcs.ca.gov/services/ccs/Pages/AdvisoryGroup.aspx

Data and Quality Measures TWG Update

Linette Scott, MD

Information Management

Deputy Director and CMIO, DHCS

Lee Sanders, MD

Stanford Center for Policy, Outcomes and Prevention

December 4 Agenda

- CCS Performance Measures and Comments Received
- Efforts to Develop Indicators for Outpatient Care for Children with Special Health Care Needs
- Follow-up to the October 21 Advisory Group Discussion – At Least One Outpatient Visit after Hospitalization

Webinar recording available on AG website:
http://www.dhcs.ca.gov/services/ccs/Pages/AdvisoryGroup.aspx

CCS Performance Measures and Comments Received

Linette Scott, MD
Information Management
Deputy Director and CMIO, DHCS

CCS County Measure 1

Definition	**Clients enrolled in CCS, including NICU infants, will have a designated physician, subspecialty physician or nurse practitioner, in a usual place of care (e.g. clinic, office, where care is provided normally), who addresses preventative, acute, and chronic care from birth through transition to adulthood.**
Numerator	The total number of unduplicated active children with a Medical Home address in the addressee tab of CMS Net Registration with the Provider Type field identifying a Certified Nurse Practitioner or Physician. A blank Medical Home or another Provider Type in the field will be designated incorrect and not counted.
Denominator	The total number of unduplicated active children enrolled in the local CCS county program.

CCS County Measure 1
Examples of SurveyMonkey Comments

- NICU – Challenge to identify a PCP for NICU infants.
- Define and monitor Medical Home (MH) – Child should have a MH (could be specialist) responsible for addressing preventative care and ensuring access to appropriate acute and/or chronic care. Incorporate 6 components of family-centered medical home.
- Definition is broad – Define “usual place of business”. Change “addresses” to “provides oversight and SCC referral for subspecialty care”. Add “appropriate access” to designated physician. Distinguish levels of care: preventative, acute, and chronic.
- SCC and families should be included.

CCS County Measure 2

Definition	**Children referred to CCS have their initial medical and program (financial and residential) eligibility determined within the prescribed guidelines per California Codes of Regulations (CCR), Title 22, and according to established CCS policy * and procedures**. Counties will measure the following:**
Numerator	a. Medical eligibility is determined within seven calendar days of receipt of all medical documentation necessary to determine whether a CCS-eligible condition exists in the last fiscal year. (CCR, Title 22, Section 42132; CCS N.L. 20-0997) Measure number of days between the referral date and the last case note within the reported Fiscal Year with a type of "Medical Documentation Received". b. Residential eligibility is determined within 30 calendar days of receipt of documentation needed to make the determination in the last fiscal year. (CCR, Title 22, Section 41610) Measure number of days between the referral date and the last case note within the reported Fiscal Year with a type of "Residential Documentation Received". c. Financial eligibility is determined within 30 calendar days of receipt of documentation needed to make the determination in the last fiscal year. (CCR, Title 22, Section 41610). Measure number of days between the referral date and the last case note within the reported Fiscal Year with a type of "Financial Documentation Received".
Denominator	Number of unduplicated new referrals to the CCS program in each county assigned a pending status in the last fiscal year. * The denominator should be adjusted to exclude children who are determined ineligible.

CCS County Measure 2
Examples of SurveyMonkey Comments

- This is solely a process measure and not a quality of care.
- Length of time should be provided. Financial clearance needs to be acquired before medical clearance which may cause delay.
- Define who will measure compliance in dependent counties where medical eligibility is determined by DCOS.
- In the Whole-Child Model, eligibility determination remains with County CCS. It would be difficult for health plans to be responsible for these guidelines.
- Include more detail as to how eligibility is determined and communicated.
- Clinical eligibility assessment should be guided by an objective set of guidelines (including specific diagnosis) and reconciled.

CCS County Measure 3

Definition	**Clients enrolled in CCS, in the identified ICD categories, will have a referral to a designated Special Care Center and an annual SCC Team Report.**
Numerator	Number of clients in CCS, with a medical condition in the following ICD categories, who actually received an authorization for SCC services in the last fiscal year: 1. Cardiac Defect: 745. or any 5-digit 745. code Cardiac Anomalies: 746. or any 5-digit 746. code 2. Cystic Fibrosis: 277. or any 5 digit 277. code Respiratory Failure: 518. or any 5-digit 518. code 3. Diabetes Type I: 250. or any 5-digit 250. code 4. Factor Disorder: 286. or any 5-digit 286. code Leukemia: 204. or any 5-digit 204. Code Sickle Cell: 282.62 or .63 or .64 or .68 or .69 5. Post-Transplant: 33.50, 33.51, 33.52, 33.6, 37.5, 37.51, 41.01, 41.02, 41.03, 41.04, 41.05, 41.06, 41.07, 41.08, 41.09, 46.97, 50.51, 50.59, 52.80, 55.61, 55.69
Denominator	Number of unduplicated CCS clients in each category and subcategory who should receive an authorization for SCC services in the last fiscal year.

CCS County Measure 3
Examples of SurveyMonkey Comments

- This is solely a process measure and not a quality of care.
- Insert timeframe for referral.
- Lists of ICD categories requiring SCC referrals, SCCs, and paneled subspecialists.
- Changed language to: "Clients enrolled in CCS, in the identified ICD 10 categories, will have a referral to a designated Special Care Center and receive risk appropriate care including, at a minimum, an annual SCC Team Report."
- Add measure - appropriate designated Specialty Care Center, what the purpose and impact of the report is, how will it be used, and measure of care coordination or family centered care or family satisfaction.
- Measure is difficult to count and time consuming to evaluate.

CCS County Measure 4

Definition	**The percentage of youth enrolled in the CCS program 18 years and older identified by ICD Categories in Performance Measure 3 who are expected to have a chronic health condition that will extend past their 21st birthday will have CMS Net case notes documentation of health care transition planning.**
Numerator	The number of youth enrolled in the CCS program who are 18 years and older identified in the denominator below who have documentation in either the Transition Planning Required Case Note or the Transition Planning Not Required Case Note identified during the Annual Medical Review for each client.
Denominator	Number of clients in CCS, age 18 through 20, with a medical condition in the following ICD-9 categories: 1. Cardiac Defect: 745. or any 5-digit 745. code Cardiac Anomalies: 746. or any 5-digit 746. code 2. Cystic Fibrosis: 277. or any 5 digit 277. code Respiratory Failure: 518. or any 5-digit 518. code 3. Diabetes Type I: 250. or any 5-digit 250. code 4. Factor Disorder: 286. or any 5-digit 286. code Leukemia: 204. or any 5-digit 204. Code Sickle Cell: 282.62 or .63 or .64 or .68 or .69 5. Post-Transplant: 33.50, 33.51, 33.52, 33.6, 37.5, 37.51, 41.01, 41.02, 41.03, 41.04, 41.05, 41.06, 41.07, 41.08, 41.09, 46.97, 50.51, 50.59, 52.80, 55.61, 55.69

CCS County Measure 4
Examples of SurveyMonkey Comments

- Define “health care transition planning”.
- More specifics on what should be documented, goals, and timeframes.
- This is a process measure – what is needed is outcomes measure such as did the youth successful transfer to adult care.
- Develop a Transfer FORM constant for all transitions/referrals that includes pertinent information; optimally, this could be done electronically
- Suggest two performance measures: One for the CCS general program at 18 and 20 years of age, and another for the MTP patients at 16,18 and 20 years.
- There should be a standardized approach to transition planning and specific goals that are met before the transition occurs.
- Transition should begin at 12 or 14, per national guidelines.

CCS County Measures
Examples of SurveyMonkey General Comments

- Discussion about possible quality measures that can be assessed from data currently collected at the state and county levels.
- Need more details on each measure with numerators and denominators.
- There is a need to track denied referrals, as the fear with the proposed transition is that the network available to children and youth with special health care needs will be narrowed.
- There is a need for care coordination, family involvement, and family centered care measures.
- Given the potential for measures to be influenced by reporting artifacts, recommend analyzing ways to accurately capture these measures.
- Special requirements and protections needed: 1. Access to subspecialty care. 2. Access to other services (e.g, home nursing, DME). 3. Quality of care to meet the special requirements of the CCS population.

Update on Analyses of CCS Paid-Claims Data

Lee Sanders, MD, MPH

CCS Advisory Group

January 6, 2016

Stanford Children's Health | Lucile Packard Children's Hospital Stanford

CHP PCOR STANFORD — Center for Policy Outcomes & Prevention

Stanford MEDICINE

“Quality Indicators” from CCS Paid Claims

OBJECTIVE: To identify quality indicators, **derivable from administrative data,** that may assess appropriate **delivery of outpatient care for CSHCN.**

METHODS

Systematic literature review

- Identify all published expert guidelines and nationally endorsed quality metrics for outpatient care of CHSCN.
- From these, propose a subset of “candidate indicators” that may be derived from administrative (paid-claims) data.

Modified Delphi Process (2014-15)

- Focus groups (8): Expand list of candidate indicators
- Surveys (3): Identify the most “appropriate” indicators
  - 17 stakeholders (MD + non-MD)
  - Each indicator rated 0 (least appropriate) to 9 (most)

“Quality Indicators” from CCS Paid Claims

48 candidate indicators across 5 domains

- ❑ Access to Medical Home Services
- ❑ Access to Pharmacy Services
- ❑ Access to Outpatient Care
- ❑ Ambulatory-Sensitive Hospitalization
- ❑ Home Health and Outpatient Therapies

19 indicators were deemed “most appropriate”

(mean appropriateness score >7)

“Quality Indicators” from CCS Paid Claims

Access to Medical Home Services

1. **Regular Primary Care Visits** (age <24 months: at least 2 visits per year; age >= 24 months: at least 1 visit per year)
2. **Regular Subspecialty Care** (at least 1 visit per year)
3. **Regular Dental Care** (age >= 24 months: at least 1 visit per year)
4. **Usual Source of Care (Physician):** Same Physician seen at least once per year for multiple years in a row
5. **Usual Source of Care (Clinic):** Same Clinic visited at least once per year for multiple years in a row
6. **Care Coordination:** At least 1 visit coded for “care coordination” or “case management” per year.

Access to Pharmacy Services

7. **For children with medication-dependent conditions:** No episode of > 90 days between prescription refills

“Quality Indicators” from CCS Paid Claims

Ambulatory Sensitive Hospitalization

8. No unplanned 30-day re-admission to hospital

9-15. No hospitalization for one of the following primary acute conditions: Dehydration, Urinary Tract Infection, Asthma, Impaction or Constipation, Anemia, Diabetic Ketoacidosis (except at time of initial diagnosis of diabetes), Feeding-tube complication

Access to Outpatient Care

16. For children who are hospitalized: At least 1 outpatient visit of any type (MD, RN, diagnostic, other) during the 30 days prior to hospitalization

17. For children who are hospitalized: At least 1 outpatient visit of any type (MD, RN, diagnostic, other) during the 30 days after hospital discharge

Home Health and Outpatient Therapies

18. For children with DME: At least 1 home health visit per year

19. For children with neurologic impairment: At least 1 PT visit per year

Summary

19 Quality Indicators from CCS Paid-Claims Data

Independent Factors Associated with Indicator Patterns

- Differential Patterns by Age
- Differential Patterns by Medical Complexity, Diagnostic Category
- Little difference by Payor Source (FFS v. MMC)

County-level Variation

- Independent of case mix (age, medical complexity, diagnoses)

Other Indicators -- NOT by paid claims data

By Parent Survey (examples):

- Unmet child health needs.
- Satisfaction with care
- Reduction or loss of parent income
- Family stress / burden
- School attendance / absence*
- Availability of 24 hour phone triage by staff experienced with CSHCN*
- Regular receipt of multi-disciplinary specialty care services*
- For families with LEP, use of interpreter services*

By Provider Survey (examples):

- Coordination with non-medical services, including school and regional centers.
- Satisfaction with communication from medical and non-medical systems of care.

By electronic health records or registries (examples):

- Use of “integrated care plan”*
- Regular screening for mental health*
- Regular screening for environmental risk (e.g., tobacco smoke, domestic violence)*
- Regular assessment of neurodevelopmental function*
- Referrals completed (%).

* Identifies indicators that may be captured from existing data sources (including Regional Centers, provider survey, EMRs, patient registry, school district records).

Stanford CPOP Policy Analyses

Policy Briefs

CCS: Enrollment by Diagnosis and Over Time
CCS: Annual Spending, by Region
Two More Years: What Does Continued CHIP Funding Mean for California?
CCS: All Inpatient Paid Claims by Site of Care
Variation in Specialty Care Hospitalizations for Children with Chronic Conditions in CA
Regionalized Pediatric Specialty Care for California's Children
Quality of Care: Outpatient Care Before Hospitalization
Quality of Care: Outpatient Care After Hospitalization
The Cost of Care for Children Enrolled in CCS
Care Use by "High-cost" Children Enrolled in CCS
Health Care Use Varies by Diagnosis among CCS Enrollees
Health Care Use Varies with Age among CCS Enrollees

Peer-Reviewed Manuscripts

Outpatient Pharmacy Expenditures (JAMA 2015)
Health Care Use and Costs for Diabetes (J. Peds 2015)
Use of Outpatient Care among VLBW Infants (submitted)
Outpatient Care Patterns as Predictors of Diabetic Ketoacidosis (submitted)

https://cpopstanford.wordpress.com/reports-and-policy-briefs/

Public Comments

Bobbie Wunsch

Pacific Health Consulting Group

Next Steps and Next Meetings

Jennifer Kent
Director, DHCS

Bobbie Wunsch
Pacific Health Consulting Group

Next Meetings

2016 CCS Advisory Group Meeting Dates:

- April 6, 2016
- July 6, 2016
- October 5, 2016

Information and Questions

- For CCS Redesign information, please visit:
  - http://www.dhcs.ca.gov/services/ccs/Pages/AdvisoryGroup.aspx
- Please contact the CCS Redesign Team with questions and/or suggestions:
  - CCSRedesign@dhcs.ca.gov
- If you would like to be added to the DHCS CCS Interested Parties email list, please send your request to:
  - CCSRedesign@dhcs.ca.gov